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‘Keeping meself to meself’ – How Social Networks Can Influence Narratives of Stigma and Identity for Long-term Sickness Benefits Recipients

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Abstract

This article focuses upon social networks and their relationship to stigma and identity for long-term sickness benefits recipients in the North East of England. Drawing on empirical qualitative research with long-term sickness benefits recipients, this article demonstrates how the co-construction of stigma is fundamental in shaping how long-term sickness benefits recipients participate in social networks with friends, family and the community. The findings support the idea that the stigma of receiving benefits can be contrasted with nostalgia for the social elements of employment. Utilizing the work of Goffman, the article focuses on how the stigma and shame felt at receiving sickness benefits for an extended period of time interacts with social networks and identity. Reluctance to disclose a claimant identity to friends and family could lead to social isolation and a perceived need to ‘keep meself to meself’ which can be linked to a wider rhetoric surrounding benefits recipients that characterizes them as ‘scroungers’.

Keywords

Social networks; Sickness benefits; Stigma; Identity; Neighbourhood; Scrounger

Introduction

Since 2008, the UK has been experiencing a period of welfare reform and austerity which has caused increasing stigma, shame and uncertainty for many sickness benefits recipients. Briefly, Employment and Support Allowance (ESA) was initially introduced by Brown’s Labour Government in 2008, and saw the attachment of work-related conditions to the receipt of sickness benefit (DWP 2008). The UK coalition Government adopted this approach, and under the ESA regime, new claimants must undergo the Work Capability Assessment (WCA), a health capacity test to determine their fitness for work.

From April 2011, those claiming Incapacity Benefit (IB) started to undertake this assessment.

Ongoing reform has, for example, led to research that has discussed the geographical distribution of welfare reform (Beatty and Fothergill 2014), the role of identity within the narratives of long-term sickness benefits recipients (Garthwaite 2015), fear over welfare reform (Garthwaite 2013), and conditionality (Patrick 2011; Weston 2012). Geographically, the work of Beatty and colleagues (also in this Special Issue) has repeatedly discussed how the highest claimant rates are nearly all found in Britain’s older industrial areas – in the South Wales valleys, in the North of England in places such as Merseyside, Lancashire, South Yorkshire, Teesside, Durham and Tyneside, and in the West of Scotland in and around Glasgow (Beatty and Fothergill 2014, 2013, 2005; Beatty et al. 2009). These are the parts of Britain where large-scale industrial job losses occurred in the 1980s and early 1990s where there has been a continuing imbalance between labour demand and labour supply.

In the UK, the popular media have contributed significantly to a hardening of attitudes to welfare recipients in recent years, characterizing benefits recipients as 'scroungers', 'lazy', 'workshy' and 'fraudsters'. The accompanying policy shifts from an emphasis on universalism to one on conditionality and selectivity has reaffirmed this (Golding and Middleton 1982; Garthwaite 2011; Horton and Gregory 2009; Sefton 2009). Drawing on data collected during a qualitative study of long-term sickness benefits recipients in the North East of England, this article is particularly interested in how narratives of those receiving long-term sickness benefits are influenced and shaped by social networks in the form of friends, family, communities and employment, and how this relates to stigma and identity.

It can be argued that a stigma is essentially an attribute of the stigmatized person. A stigma is a mark of disgrace. The mark may be a physical one, or it may be something which attaches to the person, like a stain or taint. Goffman (1963) at first refers to stigma as 'a failing, a shortcoming, a handicap' (Goffman 1963: 12); 'an attribute that is deeply discrediting' (Goffman 1963: 13); 'an attribute that makes him different from others . . . and of a less desirable kind' (Goffman 1963: 12); and 'a shameful differentness' (Goffman 1963: 21). Goffman goes on to say that, 'a stigma . . . is really a special kind of relationship between attribute and stereotype' (Goffman 1963: 14). These definitions present stigma as a personal flaw – and one which can be likened to the rhetoric surrounding benefits recipients as a result of media and government discourse. Using Goffman's (1967) notion of stigma management including 'saving face' and presenting an 'idealized self' (Goffman 1959), this article goes on to illustrate the different arenas within which stigma is co-constructed and how people receiving long-term sickness benefits are acutely aware of its potential emergence in everyday social interaction (Goffman 1963). In response, participants attempted to avoid stigma at all costs, by withdrawing from social interactions which might expose their claimant status or reveal to friends and family the extent of their health problems, leading to a compromising of their social networks.

Methods

The research presented here is based on doctoral research which was attached to a wider project involving a longitudinal survey of the health of long-term IB recipients in County Durham (Warren et al. 2013). County Durham, the site for the research presented here, is a region replete with a coal mining legacy that relates to wider, long-term processes in the economy and regional labour market, some of the highest levels of sickness benefits receipt in the country have been recorded. Figures show that there were 8.4 per cent of the working age population receiving ESA and incapacity benefits in the County Durham region in 2013, significantly higher than the national average of 6.1 per cent. In the Horden North ward of the county, this figure rises to 16.8 per cent, with a further

14.3 per cent in Easington Colliery (NOMIS 2013). All participants were initially recruited via Jobcentre Plus (JCP) 'Choices' outreach events held between September 2009 and June 2010 in the North East of England, an area where levels of deprivation, ill health and health inequalities are well pronounced. The Choices events aimed to offer a range of new and existing provision available at JCP and offered to people taking part in Pathways to Work, including initiatives such as the Condition Management Programme (CMP), Return to Work Credit and enhanced In-Work Support. Initial contact with participants was forged following attendance at the Choices events in venues such as local colleges, community centres, and leisure centres. JCP stated there was no compulsion for people to attend, and as the events were not mandatory, non-attendance would not impact upon someone's benefits receipt.

Purposive sampling was used to recruit 25 chronically ill and disabled people (15 women and ten men) who were interviewed between March 2011 and August 2011, with the majority of interviews taking place in participants' own homes. Importantly, participants involved in the research were all long term IB recipients and were predominantly yet to undergo the WCA so therefore had not been migrated onto ESA or Jobseeker's Allowance at the time of the fieldwork. This should be kept in mind when references are made to IB or Disability Living Allowance throughout this article.

Interviews lasted between 45 and 120 minutes and were transcribed verbatim and fully anonymized before thematic analysis was undertaken. The age range of the sample varied from 32 to 63. Only two participants reported growing up with health problems which were musculoskeletal in nature. Diagnoses most frequently reported included arthritis, rheumatism, fibromyalgia, cardiovascular disease, multiple sclerosis and mental health problems including depression and bipolar disorder. A substantial range existed between the lengths of time people had spent on IB – some had been receiving it for three years, whilst others had been receiving the benefit for over 20 years.

A thematic framework for analysis was derived partly from the study objectives and partly by identifying themes from ongoing analysis of transcripts. NVivo 8 software was also employed to assist with coding and to ensure transcripts had been analyzed thoroughly. All participants' names have been anonymized and any identifying information has been omitted. Ethical considerations were respected throughout the research and ethical clearance was approved in advance by Durham University Department of Geography Ethics Committee.

Findings

The importance of social networks – family and family

The importance of friends and family was a common theme throughout the narratives. Whilst for some, the support of those in their social networks was crucial in terms of their daily coping, for others, friends and family were shut out by participants who preferred to keep their health and illness narratives to themselves, often due to the stigma of being a benefits recipient.

Case study: the Wellington Men's Group

This discussion can be strengthened by looking at a case study example of the Wellington Men's Health Group. Originally set up through CMP, every Monday afternoon men with health problems in the Wellington area meet up to chat, tend to their allotments, plan what training courses they would like to do, arrange day trips and discuss any problems they may be facing, whether that may be in terms of health, benefits or other concerns. At each group, approximately eight to ten men typically in their 40s and 50s attend each week. Of particular importance here is the geographical work of Gesler (1992, 1993) on the notion of 'therapeutic landscapes'. Based on an understanding of the ways in which environmental, societal and individual factors can work together to preserve health and well-being, Gesler suggests that certain environments, in this case allotments, promote mental and physical well-being. Gesler's concept suggests that specific landscapes not only provide an identity but can also act as the location of social networks, providing settings for therapeutic activities. Furthermore, Milligan and colleagues (2004: 1787) discuss the importance of allotments and comment that such communal activity can have a positive impact upon health and well-being, but that, 'the benefits arising from the social interaction inherent within such communal gardening activity also have a powerful potential to address the UK government's social exclusion agenda'. These explanations fit neatly into the narratives of the three members of the group who were interviewed – Shaun, Fred and Ray – with all of them speaking of the significance the group has had in their lives. Fred, 53, had been receiving IB for over eight years. He used to be in the Army and had 'worked all of his life' until polyarthritis left him unable to continue being employed. Fred was referred to the group through CMP five years ago. For Fred, the group not only allowed him to enjoy social activities such as day trips, but was also a source of information and support, 'They may have experienced something I haven't like with the benefits office and they can advise me. I've actually managed to help two ex-soldiers as well just sitting in the cafe talking to them'. Ray struggled with alcoholism and for him the group was a way of giving his day 'more purpose' and providing a structure that prevented him from beginning drinking alcohol at 3 pm:

'Ganning [going] to the men's group and doing stuff like this, I think if it wasn't for stuff like this I'd be stuck in the house a lot more. It's given us a bit purpose to get out. Being at the men's group there's a bit purpose cos you're meeting other people as well cos basically at

the minute when I come here I'll start me drinking at 5, half 5. If I'm in the house not doing nowt I might kick off about 3.'

Yet for Shaun, whilst he attends the group regularly, as the chairman he feels pressure to be the person who helps everyone else with their problems; as a result he feels his own concerns are being neglected. Shaun, 42, broke his back in an accident in his job as a bricklayer and now suffers with mental health problems after 13 years receiving sickness benefits:

'I've got the support group and I tried to talk to them and they said they see me as the one who sorts problems out. It's me strength that's kept me going all these years and I just feel like I'm running out of strength. They elected us chairman and I didn't even want to be elected, so I feel I've got a responsibility now when really I can't face it.'

Fractured relationships

Many participants spoke about how their relationships with family and friends had altered following their transition onto sickness benefits, characterized by a change in identity. When asked about friends and family, Mick said:

'I do miss socialising a lot, I can't do what I used to do but life goes on, friends come to see me as well, we have a chinwag but that friendship is different. The identity of the friendship has changed 'cos I can't do the things I used to do with them, the daft things we used to do, play football and we still have the same laughs and things but at work that history of all the daft things that happened, that's sort of slowly evaporating, those stored memories. Even though I've got friends the visits aren't what they used to be.'

Nostalgia for a past identity was a theme which united the narratives. Mick spoke about his feelings of a loss of self and identity in relation to his friends— he feels things have changed between them. An equally told story was one of friends no longer visiting following the onset of chronic health problems. Shaun said:

'I was losing all me friends cos they felt uncomfortable coming round, they felt bad talking about what they were doing 'cos I couldn't do anything anymore. I decided I didn't want anything more to do with me sister after what she'd said about me [she wanted Shaun to be detained in a psychiatric hospital] and it was just horrendous.'

Similarly, Martin, age 54, had been receiving IB for five years as a result of physical health problems and alcohol misuse. Martin described how his friends no longer visited him anymore, 'All our friends the only time we saw them was in the club, but now nobody visits us. But I'm quite content because

over the years you just get used to it'. Sue, 50, had been receiving IB for 20 years after an accident at work where she fell down a flight of stairs which led to mobility issues and depression. She is also diagnosed with diabetes and has heart problems. Sue spoke about the embarrassment she felt at asking her family for help:

'I think sometimes rightly or wrongly if I'm saying to the family "Me hands are bad" I think they must think "Oh she's off again" and I don't know whether they do but I think they must think I always complain. I dunno I've never actually asked them but I'm sure they must get sick of us saying can you do this, can you do that. They shouldn't have to be doing it. Like asking Catherine [daughter] to put me socks on, fasten me bra or put me knickers on up to here so I can pull them up – it's embarrassing. I know she'll do it but she shouldn't have to and that hurts.'

These extracts suggest that suffering chronic illness can serve to isolate and separate people from their social networks, which could have a damaging effect upon their health; similar sentiments can be found in the work of Gallant et al. (2007) on family and friends in relation to chronic illness management. Others such as Sandra chose not to fully share their problems with family and friends. Concealing identities and controlling information meant not only deciding who can be given information about their illness, but also how much and what information they would be given, thereby employing a form of stigma management (Goffman 1963). Just as there was an avoidance of accepting the term 'disabled', the stigma of receiving sickness benefits could be so overwhelming that people refused to admit they were receiving it (Garthwaite 2013). In some cases, interviewees refused to reveal their 'claimant identity' to close family and friends, and would avoid social situations to avoid being asked the question. Sandra, 45, was involved in a car accident 30 years ago which left her with spinal problems, and has since developed gastric problems alongside secondary mental health concerns. Sandra had received sickness benefits for 12 years but had not revealed this to anyone other than her husband, the relevant authorities and myself. Sandra described how friends and family can fail to understand the complexities of sickness and disability – something made even more difficult given the fact that Sandra refused to disclose her long-term sickness benefits recipient status:

'I bumped into a friend who I hadn't seen for 30 years and she asked if I was working and when I said no, she was like "Oh I wish I could be a lady of leisure, I wish I had nothing to do all day" and I thought you haven't got a clue. It's like my sister she works full time and I said to her I would love to be earning £300 a week, getting a pay packet, earning money – I

would love to be in her shoes. But like I say they don't understand why I'm not working, they know I have back problems but nothing more.'

There were numerous occasions where participants described avoiding social situations which risked exposing their claimant identity and would not admit to needing help because it would mean a loss of pride or face (Goffman 1967). Here, Sandra is actively distancing herself from friends and family members as she feels ashamed and concerned about others' reaction to her illness and benefit status. Employing the theoretical framing of Goffman to offer an explanation for Sandra's behaviour, the notion of 'idealized self' (Goffman 1959: 45) occurs 'when the individual presents himself before others . . . to incorporate and exemplify the officially credited values of the society'. Indeed, according to Goffman (1963: 42), the pressure of idealized conduct is most clearly seen in marginalized people, such as long-term sickness benefits recipients, who are viewed as 'discredited'.

Stigma, Networks and the Community: 'keeping meself to meself'

Studies have emphasized the continued existence of strong, local social ties within disadvantaged neighbourhoods in diverse locations including the UK, Ireland and Australia (Gosling 2008; Leonard 2004; Olagnero et al. 2005; Warr 2005). These interactions can provide practical help (Gosling 2008; Warr 2005) as well as a sense of attachment and belonging to place (Robertson et al. 2008).

Interestingly, when asked about their local area, very few participants reflected upon the history or the importance a place can have upon health. Instead, the answer people gave when asked about the area was the same time and time again – 'I keep meself to meself'. This could be linked to wider feelings of shame and guilt related to receiving sickness benefits – as the findings presented here and elsewhere (Garthwaite 2013) suggest, people can be reluctant to reveal a 'claimant' identity to friends and family, so 'keeping meself to meself' can be perceived as an extension of that when thinking about place and community.

A clear distinction between identifying as 'deserving' benefits recipients and those in the area who they perceived as 'undeserving' was apparent in the narratives. Angie, 50, had been receiving sickness benefits for over seven years following a serious car accident which led to both physical and mental health problems. She initially spoke of her perception that many people were receiving benefits in her neighbourhood, yet when she reflected on her comments, she realized that may not be the case:

'Oh gosh yeah, even if they're not supposed to be. The girl who was living next door she's gone now but she was working a couple of jobs and then she was claiming as well and she got caught but I mean . . . although Amanda next door has jobs, the house at the end

Stephanie she goes cleaning, Sally works with handicapped kids, next door they both work, the next door I think they work so . . . maybes y'know there's not that many. When you sit and think about it, maybe there aren't many on benefits here so it might not be that bad. But like I say I tend to keep meself to meself.'

The importance of community was alluded to by several participants in the study, such as Linda and Mick, as shown in these extracts below. Linda, 54, had physical health problems which she attributed to working in factories for many years, together with mental health problems that developed following her exit from the labour market. Linda said, 'I like getting outside, getting out in the back lane when someone's out. We've had some laughs up here it was all community, a hell of a community. Like I say we always have little bonfires, parties . . . its great up here when it's like that'.

Welfare and the neighbourhood

In their study of attitudes to welfare recipients and neighbourhoods, Bailey et al. (2013) comment how living in a poorer neighbourhood could be associated with exposure to slightly less supportive attitudes and hence a weaker, negative effect on residents' attitudes. For Shaun, the downside of community could be found in his neighbours' attitudes towards him and his condition:

'The amount of times I've heard the neighbours saying "He's supposed to be bad but look he's going out for the night" and I felt like turning round and saying "Hang on a minute" and I hate it, to the point where now that I've moved again to a different area I deliberately keep meself to meself.'

Again, the quotation from Shaun's interview highlights how stigma encourages him to withdraw from social networks in his neighbourhood resulting in him 'keeping meself to meself'. Efforts to limit social contact with other residents were also evident in research by Crisp (2013). A number of residents in his study of disadvantaged neighbourhoods articulated a desire to 'keep themselves to themselves'. Crisp (2013) explains that tendencies to regulate contact with neighbours was expressed in terms of choice which can be seen as fitting into the ideas of 'community unbound'. This term refers to broad changes in the social and economic structure have reduced reliance on neighbours and encouraged a 'privatization of community' (Blokland 2003) which includes a growing preference for more intimate networks of family and friends.

On occasions, but not often, participants did talk about how the decline of the local labour market in County Durham and the North East had an impact upon their narratives. For example, Linda, explained how she felt her job prospects were being restricted and why, 'I couldn't work in a shop, petrol stations aren't the same, I haven't done anything else. All I've ever done is work in a factory

since leaving school. There is no factories they're all shut, every one I've worked in has closed down, every single one'. Joan, 52, reflects upon how the area has changed since it ceased to be a working pit village, 'It's not as lively an area as it used to be and there's clubs closing down, there's not a lot of shops open now, the library's gone it's now a car park'. Indeed, Cattell's work (2001: 1504) highlights how dwindling facilities like social clubs and local shops mean that there are fewer casual meeting places on the estates she studied than there once were, but those remaining continue to have significance for fostering the weak ties necessary for a vibrant community life and which her interviewees suggested contributed to their own sense of well-being as can be seen in Linda's comments about 'getting out in the back lane'. Although some participants were reluctant to engage with social networks, generally narratives revealed recognition of the benefits of employment not just financially, but socially, morally and for their health and well-being.

Missing 'the craic': The Social Side of Working

Work constitutes a key part of how we construct, define, transform and make sense of our own and others' identities (Bain 2005). The social aspect of work was described as being incredibly important for participants, and something that was hugely missed following their transition onto long-term sickness benefits. This transition from paid employment was also instrumental in shaping current identities (Garthwaite 2015). Jennifer, 56, and her husband were both receiving sickness benefits. Jennifer had arthritis alongside severe mental health problems and a host of other physical health concerns and had been receiving sickness benefits for 12 years. Jennifer said, 'I would love to work, it's like you if it happened to you you'd think "I'm stuck what am I gonna do?" I bet when you have holidays you get frustrated and want to be back at work. It's social, socialising and we haven't got that no more'. Talking about the importance of work to her, Linda was enthusiastic about how 'the craic' or social side of working in a factory was appealing to her:

'It was very important, I loved it. The girls, the craic, we had a hell of a laugh. Music on all day, singing, dancing, carrying on . . . it was one big laugh from start to finish. There's nothing like working in a factory I loved it, it was a blast. As long as you got your work done it didn't matter what you were doing, as long as you kept that line going. I loved it.'

Angie's interview revealed a similar sentiment. For her, work was important due to the social aspect that accompanied it:

'I loved to work. I worked in the doctors we were all friends I had meals out, things like that. You know what it's like, you work. We used to go to London together, things like that and

[when you come out of work] you lose everything, you lose your friends, you lose your job which I loved me job, I love people working with people and I just loved it all, I really did.'

Both Jennifer and Angie were keen to stress how as the researcher, I am employed and would, like them, miss the social aspect of work if it was absent. This again reinforces the stigma they felt at being 'discredited' (Goffman 1963) and having to claim for sickness benefits. Kirsty, 33, a prison officer for ten years until an accident at work left her with permanent spinal problems, spoke of her concerns over the absence of work within her identity:

'The first question people always ask you after your name is "What do you do?" and it kind of defines you. I usually just say to people "I don't, I retired when I was 30" and they give you a double take and wonder what the heck you're going on about but yeah it does define what you do. People look at you and think "There's bugger all wrong with you". I've had that conversation so many times with people and you're having to justify why you don't have a job. I would rather be able to turn around and say anything really rather than that.'

The problem with unemployment is not the lack of resources as such, but the deprivation of the legitimate means by which resources are secured by employed people and the demoralizing effect this has on people 'in terms of a series of lacunae associated with a state of non-working' (Walters 2000: 85), as can clearly be seen in Trevor's narrative. Trevor, 59, was involved in a motorbike accident which left him with neck and arm problems. He had been receiving sickness benefits for nine years and said:

'It was pretty tough 'cos I'd been doing that job for 30 years and to lose all me friends, me contacts basically coming back home . . . although I classed it as home it wasn't really 'cos I had no friends here, friends I'd grew up with and served my time with in the ship yards I hadn't seen them for 20 odd years. So . . . it was tough, psychologically tough. Then obviously once I was capable and got me confidence back and came off all the drugs I was on I got me confidence back, then I had to set about thinking "What am I gonna do employment wise?" 'cos I had to get a job, I've always worked.'

For Trevor, unemployment meant a state of deficit in relation to a set of 'enduring human needs' that are provided for by paid work (Jahoda 1982: 60). Unemployment takes away shared experience; a structured experience of time; collective purpose; required regular activity; and, lastly, status and identity. 'What do you do?' remains a question strangers wonder about each other when they meet. It is also important to view the appeal of work in terms of a desire to avoid the shame and stigma experienced due to the lack of it in an individual's narrative.

Discussion and Conclusions

This article explores the processes that long-term sickness benefits recipients engaged with in order to negotiate stigma and identity in their social networks. In particular, it seeks to contribute to discussions centred on attitudes to welfare recipients, communities and employment.

First, narratives were filled with isolation and exclusion which was exacerbated by the negative discourse which surrounds sickness benefits receipt in populist media representations. As a result of this pejorative discourse, together with burgeoning welfare reform, long-term sickness benefits recipients can experience stigma that results in them 'keeping meself to meself' and therefore withdrawing from social networks and ties. Yet this ignores the complexity of life as a sickness benefits recipient in often disadvantaged communities. Indeed Baumberg et al. (2012) suggest there is a genuine link between negative media coverage and stigma – although we can only fully appreciate the media's impact when we consider its inter-relationship with people's everyday experiences. This article shows that whilst the presence of friends and family may have positive influences upon an individual's narrative, they can also bring negative influences for the individual to contend with.

One way of explaining this finding is to try to understand and appreciate the complexity of living in deprived communities such as those in the study. Research by O'Leary and Salter (2014) found that multiple disadvantage is a story of interdependence between people, not just between problems. In particular, families can provide a vital extra layer of resilience, helping people in ways and at times that statutory services cannot. Policy often does too little to take account of this interdependence. Policies can serve to actively undermine the kind of self-help and mutual support that families engage in. Reforms such as the under-occupancy penalty (the 'bedroom tax') have left people with the choice of either finding more money for rent or moving away from the support networks that make life liveable for many. On the other hand, and as the findings here have shown, fractured relationships with family and friends can diminish people's capacity to flourish (O'Leary and Salter 2014; MacDonald et al. 2005; Spano 2002).

Second, neighbourhoods are vulnerable to being stigmatized with implications for residents' social networks, experiences of social connectedness and opportunities for developing or accessing social capital. Airey (2003) describes how residents in her study actively constructed social problems in Kirkhead as being perpetrated by specific groups of (other) people in specific (other) places within the neighbourhood. Airey (2003) has also argued that neighbourhood reputation can lead to psychosocial stress through the experience of shame, despite attempts to resist being 'tarred with the same brush'. These kinds of concerns also reflect the findings of a recent study by Chase and

Walker (2013), who suggest that shame as a result of poverty can have a destructive impact on social solidarity, as people are keen to distance themselves from the 'Other' who is poor and 'not like them'. In an area such as County Durham where levels of sickness benefit receipt are much higher than the national and county averages, people living in the area can stigmatize other benefits recipients as the 'Other', as shown in the example given by Angie, who believed there were many more people receiving benefits in her community than was actually the case. Research in deprived communities in Teesside shows similar findings; in order to engage in identification (with 'the ordinary') and disidentification (from 'the undeserving') participants created phantom Others; an 'underclass' situated financially, culturally, socially and morally below them (Shildrick and MacDonald 2013: 299). Bush and colleagues extend Goffman's (1963) notion of stigma beyond the individual to space and place, and illustrate how an area can gain a 'spoiled identity', or be 'discredited' with reference to several sources of stigma, including, health stigma and social stigma (Bush et al. 2001: 53). Furthermore, they argue that people living within a 'stigmatised place' can be discredited with the 'same characteristics as those attributed to the place where they live' (Bush et al. 2001: 52).

Third, the narratives of long-term sickness benefits recipients presented in this study reveal biographies which recognize the social importance of work. Of particular note here is how people's experience of the stigma of claiming sickness benefits and their nostalgia around employment clashes with the government and media rhetoric that suggests that many people make a 'lifestyle choice' to be on benefits. Pahl et al.'s (2007) study of attitudes towards inequality found that groupings were identified on the basis of orientation to work. Interviewees made moral distinctions between people who were willing to work, people who were unable to work, and people who were not prepared to work. Those not prepared to work were labelled 'scroungers', 'parasites' and 'work-shy'. According to Smith (2005), the pervasiveness of such discourses forces individuals on the margins of the labour market to strive to assert a positive identity by distancing themselves from others deemed less worthy within the same neighbourhood. This process of 'Othering' can help define the self and affirm identity whilst reducing the stigma associated with occupying particular social and spatial locations (Crisp 2013). This raises the question as to whether, in fact, the problem is not so much unemployment at all. Rather, the current conception of what qualifies as legitimate 'work' activity in policy, political and popular discourse is the problem. As long as this privileging of paid work remains central to the idea of the responsible citizen (Dean 2003; Dwyer 2010), then those unable to participate in 'jobs' in the formal labour market will remain at risk of exclusion and vilification.

Perhaps a shift in what is accepted as work participation for all working-age adults might open up opportunities to address stigma, such as caring, volunteering and parenting, which aside from paid employment can also provide sickness benefits recipients an identity (Garthwaite 2015). For participants in this study, work was seen as bringing with it a social identity that was a source of pride and achievement, revealing an antithesis to the scrounger myth much popularized in the media, and perhaps reflecting the power of government rhetoric on the importance of paid work. There is quite clearly a visible link between how people construct work as being important, and how the government frames this in a very similar way. Such a framing by participants could be interpreted as an argument for a continuation of welfare-to-work activation policies; however, this would ignore the complex reality of welfare reform which brings stigma, isolation and suffering for those who are experiencing it.

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